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A 60-year-old female presented with a three-year history of virilizing symptoms including facial hirsutism and deepening of voice. Her medical history was significant for renal transplantation with immunosuppressive therapy consisting of mycophenolate, cyclosporine, and low-dose prednisone. She was noted to have temporal balding and darkly pigmented terminal hair on the upper lip, cheeks, chin, shoulders, and sternum. Pelvic examination revealed clitoromegaly. Menarche occurred at age 12 with regular menstrual cycles until menopause which occurred at age 50. She had two pregnancies: a miscarriage followed by a successful pregnancy.

Labs revealed an elevated total testosterone of 530 ng/dL (< 60 ng/dL), free testosterone 14.8 ng/dL (<0.87 ng/dL), androstenedione 2140 ng/dL (<200 ng/dL), and 17-hydroxyprogesterone 704 ng/dL (<285 ng/dL). LH, FSH, and estradiol were inappropriately normal in this postmenopausal female. Prolactin, TSH, DHEA-S, IGF-1 were within normal limits. Transvaginal ultrasound found a 2 cm hypoechoic right ovarian mass which was confirmed on MRI. MRI also revealed a 5 mm right adrenal nodule. Tumor markers including CA-125, Inhibin A, Inhibin B, HCG, and AFP were within normal limits. Dexamethasone suppression testing did not lower the testosterone level. 17-hydroxyprogesterone level after cosyntropin stimulation testing was 704 ng/dL (<1000 ng/dL). The patient underwent laparoscopic bilateral oophorectomy and salpingectomy, pelvic washout and omental biopsy. Pathology was consistent with a benign Leydig cell tumor. Following oophorectomy there was complete normalization of the total testosterone level (15 ng/dL, n< 60 ng/dL).

A thorough history and physical exam is vital in determining the cause of hirsutism. Medications, including over-the-counter and herbal formulations should be carefully reviewed. Although cyclosporine has been associated with hirsutism, patients typically present with vellus hair formation in the affected areas rather than darkly pigmented terminal hair. In this case, hirsutism progressively worsened following menopause and physical examination was significant for virilization. Hirsutism in a combination with virilization is typically neoplastic in nature. Endogenous androgen production can originate from either the adrenal glands or ovaries. In our patient, with workup showing both ovarian and adrenal as potential sources of endogenous androgen production, an adrenal cause was excluded due to a normal DHEA-S level at baseline and a lack of suppression of testosterone after dexamethasone suppression testing. As a result, the source was localized to the ovary. While excessive androgen production resulting in virilization is seen with ovarian tumors, Leydig stromal cell tumors are extremely rare and account for less than 0.1% of all ovarian tumors.

Reproductive Endocrinology

TRANSGENDER CARE

"It Wasn't for the Sake of Me and My Mental Health": Transgender People's Perspective on the Role of Mental Health Providers in Initiating Gender-Affirming Hormones - a Qualitative Study

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Introduction: Hormone therapy can be an essential part of medical transition for some transgender people. Despite ongoing debate on the role of mental health providers in the initiation of gender-affirming hormones, little evidence exists to guide the discussion. We seek to elucidate the patient perspective on the feasibility, utility, risks, and benefits of mandatory mental health evaluation (MHE) prior to hormone initiation.

Methods: We conducted semi-structured interviews with individuals who have initiated gender-affirming hormone therapy (n=21). We purposively sampled respondents to include those who indicated that they were required to have mental health evaluation prior to hormone initiation, and those who did not. A transgender advisory board helped develop the semi-structured interview guide. Interviews were transcribed verbatim and coded using emergent and a priori codes.

Results: The majority of respondents saw the requirement for MHE prior to hormone initiation as distinct from, and often discordant with, their mental health care. We identified the following roles of mental health care as seen by patients: 1) General psychosocial support; 2) Identity formation: therapy as a safe space to explore gender and self; and 3) Logistics: assistance navigating the healthcare system. Themes that emerged regarding the MHE requirement included 1) Access: for some, the MHE requirement delayed access to gender-affirming care; 2) "pathologizing my existence": the effects of having one's identity result in a diagnosis of mental disorder; and 3) "auditioning" for care: fear of being denied care if one does not present with a stereotypical transgender narrative. Many participants drew direct connections between the MHE requirement and negative effects on their mental health and the patient/provider relationship, while concurrently identifying mental health care as essential for wellbeing.

Conclusion: While mental health care is appreciated, many transgender people see the universal MHE requirements as having significant negative implications on access, safety, and on even on their mental health. Guidelines should explicitly account for and mitigate the structural barriers preventing transgender individuals from accessing medical and mental health care.

Reproductive Endocrinology

TRANSGENDER CARE

A Cross Sectional Analysis of the Prevalence of Co-Morbidities in Older Transgender Individuals Receiving Hormone Affirming Therapy in Comparison With the General Population

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